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Columbus Podiatry & Surgery

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www.columbusfoot.com



Patient Information

Last: _____	First: _____	MI _____	
Date of Birth: _____	Age: _____	Sex: _____	SSN: _____
Address: _____			
Home Phone: _____	Cell Phone: _____		
Work Phone: _____	Email: _____		
Best time and place to reach you during business hours _____			
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Minor <input type="checkbox"/> Partnered for _____ years			
Employer/ School _____		Employer/School Phone: _____	
Responsible Party Name: _____		Relationship: _____	
Address: _____		Phone: _____	
Please check all that apply: <input type="checkbox"/> Parent/Legal Guardian <input type="checkbox"/> Medical DPOA <input type="checkbox"/> Financial DPOA <input type="checkbox"/> Medical POA <input type="checkbox"/> Financial POA			
How did you hear about our practice? _____			

Insurance Information

Primary Insurance _____	Policy #: _____	
Group#: _____	Provider Services Phone: _____	
Address _____		
Subscriber's Name: _____	Relationship to patient: _____	
Date of Birth: _____	SS# _____	Employer: _____
Secondary Insurance _____	Policy#: _____	
Group # _____	Provider Services Phone: _____	
Address _____		

AUTHORIZATION FOR TREATMENT, INSURANCE ASSIGNMENT AND RELEASE, AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby certify that I have insurance coverage with the carriers listed above and assign directly to Columbus Podiatry & Surgery, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also agree to be responsible for charges for services to above patient, in excess or partial coverage of, by insurance as per the guidelines of Medicare, Medicaid, or applicable Private Insurance. I authorize the use of my signature on all insurance submissions. I also authorize the use of medical information pertaining to the above patient as deemed appropriate within the guidelines of the HIPAA act.

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such treatments and procedures upon me as deemed reasonable and necessary by Columbus Podiatry & Surgery Inc., and I agree to be responsible for decisions relating to such. I acknowledge that I was provided the Notice of Privacy Practices, and that I have read (or had the opportunity to read if I chose) and understood it.

Signature of Patient or Authorized Representative

Date

What is the chief complaint for which you came to be treated? _____

Is there any personal or family history of diabetes? Yes No

Have you ever been to a Podiatrist before? Yes No

If yes, please list the name of the Podiatrist: _____ Last visit: _____

Please indicate which foot problems you now have or have had in the past:

Ankle pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flat feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Athlete's foot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or leg cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bunions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heel pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corns and calluses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ingrown toenails	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cramps and numbness in the feet or legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Plantar warts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tired feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in ankles or feet	<input type="checkbox"/> Yes <input type="checkbox"/> No

Your occupation: _____ Cigarette/Tobacco use: Yes No If yes, years smoked: _____

Do you drink alcohol? Yes No If yes, how often? _____

Athletic activities in which you participate (please list and indicate frequency) _____

Place a mark "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to medications	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash (persistent)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves or joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen neck glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	PAD/PVD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No			Weigh loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear problems	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Please list any surgeries you have had (please list year for each): _____

Hospitalization other than for the surgeries listed: _____

Family Physician: _____ Phone: _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No

If yes, please list physician name and explain: _____

Please list any drug allergies (anesthetics and medications) _____

Pharmacy Name: _____ Pharmacy Phone: _____

Please list any medication you are currently taking: _____